COUNTY OF LOS ANGELES | ORDER FOR RELEASE | DEPARTMENT OF MEDICAL EXAMINER

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Please read and answer all the following questions before signing

Was the decedent legally married at the time of death?	Yes ☐	No ☐
Does the decedent have any living adult children?	Yes ☐	No ☐
Does the decedent have any living parents?	Yes ☐	No ☐
Does the decedent have a durable power of attorney or Advanced Health Care Directive under Probate Code Section 4600 et seq?	Yes ☐	No ☐

Case No.

Case Name

HEALTH .AND SAFETY CODE § •7100• CUSTODY .AND DUTY OF INTERMENT

"WARNING: The person signing this Order for Release is liable for all damages caused by any untruthful statements contained in this document. (Health and Safety Code Section 7110). It is also a criminal offense to knowingly file a false statement with a government agency. (Penal Code Section 115 and 470)"

(I) An agent under a power of attorney for health care who has the right and duty of disposition under Division 4.7 (commencing with Section 4600) of the Probate Code;

(2) The competent surviving spouse;

(3) The sole surviving competent adult child of the decedent or, if there is more than one competent adult child of the decedent, the majority of the surviving competent adult children.

(4) The surviving competent parent or parents of the decedent. If one of the surviving competent parents is absent, the remaining competent parent shall be vested with the rights and duties of this section after reasonable efforts have been unsuccessful in locating the absent surviving competent parent.

(5) The sole surviving competent adult sibling of the decedent or, if there is more than one surviving competent adult sibling of the decedent, the majority of the surviving competent adult siblings.

(6) The surviving competent adult person or persons respectively in the next degrees of kinship;

(7) A conservator of the person or estate appointed under Part 3 (commencing with Section 1800) of Division 4 of the Probate Code when the decedent has sufficient assets.

(8) The public administrator.

Therefore, please release the body upon completion of your death investigation of said deceased to:

NAME OF MORTUARY | MORTUARY TELEPHONE NUMBER

NAME OF NEICT-OF-KIN (PLEASE PRINT LEGIBLY) | RELATIONSHIP | NEICT-OF-KIN'S SIGNATURE

ADDRESS | CITY | STATE: | ZIP CODE | TELEPHONE NUMBER | DATE SIGNED

IF THE LEGAL NEXT-OF-KIN JS NOT HANDLING, PLEASE ENTER NEXT-OF-KIN INFORMATION BELOW .AND EXPLAIN WHY THEY .II.RE NOT H1lNDLING. ATTACH SUPPORTING AUTHORIZATION DOCUMENTS, E.G. WILLS, POWER OF ATTORNEY, FAXES, ETC.

NAME | RELATIONSHIP | ADDRESS / CITY / STIITE / ZIP CODE | TELEPHONE NUMBER

Only to be fllled out on the day of pick up/Release.

MOR!'IIIIR!'IIITTENDIINT/DIUVER,

nRSTNAME | LIISTNAME

NAMEOFTRANSPORI'COMP.ANY:

IIIITEOFPICKDP

For Medical Examiner Personnel Only

APPROVING SENIOR/SUPERVISOR | CRYPT

ADDITIONAL DECEDENT INFORMATION ON REVERSE

760739 - (REV. 3/2025

County of Los Angeles **INFORMATION OBTAINED BY MORTUARY FROM FAMILY** Department of Medical Examiner

Attending Physician: _____ **Phone:** _____

Address: _____ **Date Last Attended:** _____

Diagnosis: _____

_____

Surgery: _____ **Date:** _____ **Hospital:** _____

WITNESSED DEATH: **OYes ONo Ifno, LAST KNOWN ALIVE Date:** _____ **Time:** _____

Date and Time Discovered: _____ **Where:** _____

ByWhom: _____ **Police Agency Investigated: Ges** ☐ **No**

IfYes - Name and Division of Police Agency: _____

REST HOME OR CONVALESCENT HOSPITAL DEATH: Date Admitted: _____

Admitting Diagnosis: _____

_____

TERMINAL EVENT OR HOW DISCOVERED/ KNOWN MEDICAL HISTORY, RECENT COMPLAINTS OF ILLNESSES AND ANY PERTINENT INFORMATION:

_____

_____

_____

_____

HISTORY OR EVIDENCE OF INJURY: **OYes** ☐ **No TYPE OF INJURY:** _____

Date and Time of Injury: _____ **Address:** _____

City: _____ **State:** _____

At Work: OYes ONoAtHome: OYesONo IfNeither, where: _____

How Did Injury occur: _____

_____

ALL MEDICAL EVIDENCE LIST BELOW

llNo	Date Filled:	Contents:	Amount Prescribed:	Amount Remaining:

Decedent Gender Identity: _____ **Decedent Sexual Orientation:** _____

THIS FORM COMPLETED BY: _____

DECEDENT PERSONALLY IDENTIFIED BY:/ IDENTIFICATION HECHA POR:

Signed / Firma: _____ Witness / Testigo: _____

Print / Molde: _____ Print/ Molde : _____

(ESCRIBA EN LETRA DE MOLDE)

Address / Domicilio: _____ **Address/ Domicilio:** _____

City / Ciudad: _____ **City/ Cuidad:** _____

Telephone No. / Telefono: _____ **Date Signed / Fecha De Firma:** _____